

**Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, D.C. 20554**

In the Matter of

Request for Review of
GCI Communication Corp. of
Decision by Universal Service Administrator

WCB Docket No. 02-60

Yukon Kuskokwim Health Corporation
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REQUEST FOR REVIEW

Tina Pidgeon
Vice-President –
Federal Regulatory Affairs
Christopher Nierman
Director – Federal Regulatory Affairs
GENERAL COMMUNICATION, INC.
1350 I Street, N.W., Suite 1260
Washington, D.C. 20005
(202) 457-8812

John T. Nakahata
Brita D. Strandberg
Rachel W. Petty
WILTSHIRE & GRANNIS LLP
1200 Eighteenth Street, N.W.
Washington, D.C. 20036
(202) 730-1300

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REQUEST FOR REVIEW

I. INTRODUCTION AND SUMMARY

Pursuant to 47 C.F.R. § 54.719, GCI Communication Corp. (“GCI”) requests that the Federal Communications Commission (“FCC” or “Commission”) review and reverse the June 24, 2010 decision (the “USAC Decision”) by the Rural Health Care Division (“RHC”) of the Universal Service Administrative Company (“USAC” or “Administrator”) denying eligible portions of service funding for 36 facilities of the Yukon-Kuskokwim Health Corporation (“YKHC”). GCI is aggrieved by USAC’s decision because it is the service provider for YKHC and will likely not be paid for the amounts for which USAC has denied funding for the disallowed amounts unless USAC’s decision is reversed. GCI also hereby supports YKHC’s Request for Review of the USAC Decision.

II. FACTUAL BACKGROUND

The Yukon-Kuskokwim (“Y-K”) Delta is a remote area of southwestern Alaska, located approximately 400 miles west of Anchorage. The Y-K Delta is not connected by road to Anchorage or Fairbanks, Alaska’s two largest cities. The only way to reach the Y-K Delta is by airplane or boat. Like much of rural Alaska, the Y-K Delta contains a regional center, Bethel (population of approximately 5,800), surrounded by a number of smaller villages. These villages and Bethel are also not connected by roads, but can only be reached by snowmachine, dog sled, airplane, or boat.

The YKHC is the rural health care provider that supports nearly 50 rural communities in the Y-K Delta. These communities are comprised principally of Alaska Natives who reside in some of the most rural and remote portions of southwest Alaska. YKHC’s services include health promotion and disease prevention programs, dental services, behavioral health services, including psychiatric and substance abuse counseling and treatment, ophthalmological care, and

environmental health services.¹ In almost all cases, YKHC facilities provide the only health care service options available for the individuals who live in areas served by YKHC.²

To serve these remote communities, YKHC's organization includes a regional hospital, Subregional Clinics, and local community-based clinics, which YKHC refers to as "Village Clinics."³ YKHC's ability to serve patients in the most rural, remote, and sparsely populated portions of southwest Alaska depends on the use of telemedicine, which, in turn, depends on broadband connectivity and advanced technologies such as medical telemetry, digital medical and dental imaging, and high definition video conferencing.⁴

As of early 2008, YKHC received its rural health care program supported telecommunications services from United Utilities, Inc. ("UUI"), the incumbent local exchange carrier.⁵ Under its contract with UUI, YKHC procured asymmetric satellite-based links at 1.5 Mbps download and 512 kbps upload to connect its Village Clinics to Bethel.⁶ YKHC ultimately determined that this low level of asymmetric bandwidth would not be sufficient to operate the telemedicine facilities that it deemed necessary, including full motion, high definition video conferencing.⁷ YKHC also had been experiencing substantial service problems in its UUI-provided satellite services.⁸ Consequently, on April 9, 2008, YKHC posted Form 465 announcing its intent to procure:

¹ Attachment M at 1 (YKHC October 30, 2009 Response to USAC July 31, 2010 Request for Information).

² *Id.*

³ *Id.*

⁴ *Id.*

⁵ *Id.* at 2.

⁶ *Id.*

⁷ *Id.*

⁸ *Id.* at 2-3.

Services and technology required for transmitting health care data, patient record and medical images from health aide to physician consultants. This includes YKHC based physicians and contracted service providers, some of which are outside the YKHC service area. These services are for EMR, VTC and Tele psychiatry, and include CT scanner images, PACS images and Internet services. Additional T-1s or greater are required for supporting additional healthcare service needs and technology requirements.⁹

On May 7, 2008, GCI submitted a proposal to YKHC in response to YKHC's Form 465.¹⁰ Not surprisingly, given the fact that only two telecommunications carriers (GCI and AT&T Alascom) provide interexchange service within the Y-K Delta and between the Y-K Delta and the rest of Alaska, GCI was the only entity that submitted a proposal to YKHC.¹¹ On August 12, 2008, YKHC and GCI executed a contract, HC-218, for GCI to provide reliable, predominantly terrestrially-based telecommunications services to support YKHC's network. Significantly, contract HC-218 provided for symmetrical, high-bandwidth services of 3 or 5 Mbps, depending on whether a served site is a Village Clinic or a Subregional Clinic, to support, among other things, high-definition video conferencing between YKHC's hospital in Bethel and its Village and Subregional Clinics in the rest of the Y-K Delta.¹² However, these high-bandwidth inter-village connections supported not only high-definition video conferencing (with multiple Video Teleconferencing terminals ("VTCs") in the Subregional Clinics), but also

⁹ Attachment S (YKHC Form 465 for Funding Year 2008).

¹⁰ Attachment O at 6 (YKHC May 4, 2009 Response to USAC April 14, 2009 Request for Information).

¹¹ Attachment M at 3 (YKHC October 30, 2009 Response to USAC July 31, 2010 Request for Information). GCI acquired United Utilities and its interexchange subsidiary, Unicom, on June 1, 2008, after receiving FCC approval. *See* General Communications, Inc., Form 10-K (2008), <http://www.gci.com/investors/gciform10k123108final.pdf>; *Notice of Non-Streamlined Domestic 214 Application Granted*, Public Notice, 23 FCC Rcd 8232 (2008).

¹² Attachment E at 2 (YKHC's April 9, 2010 Response to USAC March 19, 2010 Request for Information).

Internet access, sharing of electronic medical records, e-mail, VoIP telephony services, remote management support functionalities and, in the Subregional Clinics, digital mammography.¹³

On various dates between August and November 2008, in accordance with the provisions of the contract, which required scheduled circuits to be turned up “as soon as commercially practicable,” GCI installed and turned up either 3 or 5 Mbps capacity transparent LAN service between a Subregional or Village Clinic and YKHC’s main hospital in Bethel.¹⁴ Upon turn up, those transparent LAN services were used immediately upon turn up for services such as VoIP telephone service, email, Internet connectivity, and other telemedicine activities.¹⁵

In the spring of 2008, YKHC was also procuring the VTCs that it would install and use for its telemedicine applications. YKHC obtained a \$500,000 grant from the Rural Utilities Service to procure VTCs, of which YKHC spent \$478,290 for the purchase of VTC equipment itself.¹⁶ GCI procured the VTC equipment and resold it to YKHC in a separate, non-supported, contract.¹⁷ GCI, however, only procured the VTC equipment and did not provide installation services, including the electrical work needed to prepare each YKHC site. Indeed, as USAC indicated in its letter to YKHC dated July 31, 2009, had GCI provided installation, GCI could have run afoul of USAC’s policy against additional free or discounted services supplementing

¹³ *Id.* at 6.

¹⁴ *See* Attachment A (Summary of USAC Funding Decisions). Other Village Clinics, which did not receive and were not anticipated to receive a VTC, had connections of 1.5 Mbps. These other clinics are not part of this appeal.

¹⁵ *See* Attachment E at 10 (YKHC’s April 9, 2010 Response to USAC March 19, 2010 Request for Information).

¹⁶ Attachment M at 2 (YKHC October 30, 2009 Response to USAC July 31, 2010 Request for Information).

¹⁷ *Id.*

the supported discounts.¹⁸ Thus, USAC had policies that specifically discouraged GCI from assisting with VTC installation.

As it turned out, YKHC was not able to install all of the VTCs as quickly as it had hoped. RUS warned YKHC that the terms of its matching grant prohibited the use of grant funds to pay an affiliate for installation. YKHC explored whether it could use a portion of the grant to fund installation through external providers and learned that the cost of doing so would exceed \$100,000. If YKHC had used grant monies for VTC installation, it would have been in the untenable position of not being able to furnish VTC equipment for all the Village Clinics for which it had planned VTC deployment. YKHC had not budgeted for this expense and did not have additional funds available at the time to pay for the installation costs at its Subregional and Village Clinics, which are scattered in remote regions of the Y-K Delta.¹⁹ The onset of winter in this remote region of rural Alaska further narrowed the options available to YKHC, as the weather alone sometimes limits the ability to travel even short distances in that portion of the state.²⁰ Fortunately, YKHC was ultimately able to enlist the support of the United States Marine Corps, as part of Operation Arctic Care, to complete its VTC installation in the villages.²¹

On June 24, 2010, USAC issued Funding Commitment Letters that refused reimbursement for the costs of the transparent LAN services that GCI actually provisioned during the period between circuit turn up and YKHC's installation of the VTCs. Specifically, USAC denied funding for any bandwidth in excess of 1.5 Mbps for the period before VTC

¹⁸ See Attachment N at 2 (USAC July 31, 2009 Request for Information to YKHC), citing USAC's "Free Services Advisory" for the Schools and Libraries support mechanism, <http://www.usac.org/sl/applicants/step06/free-services-advisory.aspx>.

¹⁹ See Attachment M at 5 (YKHC October 30, 2009 Response to USAC July 31, 2010 Request for Information).

²⁰ *Id.* at 5, 10.

²¹ Attachment R at 3-4 (USAC June 24, 2010 Funding Year 2008 Funding Commitment Letter).

installation, denying a total of almost \$1.6 million in funding. Citing discussion from the *Universal Service First Report and Order* in which the Commission *declined* to impose requirements that rural health care providers have CPE or internal connections in place prior to ordering services,²² and ignoring the fact that the Commission in 2003 again declined to impose supplementary requirements on a rural health care provider's procurement of cost-effective services,²³ USAC refused support for services above symmetric 1.5 Mbps prior the installation of the VTCs, explaining that "the increased bandwidth was not necessary for the provision of health care until the VTC equipment was installed."²⁴ In justifying the denial of this portion, USAC claimed that "the FCC expects health care providers to obtain the necessary internal connections or equipment before ordering services."²⁵ USAC rejected YKHC's explanation of budgetary and weather reasons for the delay. Instead, USAC found that even though the "delay may have been caused in part by [weather] circumstances outside YKHC's control, . . . such factors are foreseeable given YKHC's location."²⁶ According to USAC, YKHC should have "had a plan" to avoid initiation of the higher bandwidth services until the VTC equipment was installed.²⁷ Accordingly, USAC reduced YKHC's funding commitments by a total of \$1,589,119.98. As an aggrieved party, GCI now appeals USAC's reduction of funding commitments.

²² *Id.* at 3, citing *Federal-State Joint Board on Universal Service*, Report and Order, 12 FCC Rcd 8776, ¶ 727 (1997) ("Universal Service Order").

²³ *Rural Health Care Support Mechanism*, 18 FCC Rcd 24546, 24575-6 ¶ 58 (2003).

²⁴ Attachment R at 4 (USAC June 24, 2010 Funding Year 2008 Funding Commitment Letter).

²⁵ *Id.* at 4.

²⁶ *Id.*

²⁷ *Id.*

III. USAC’S DENIAL IS CONTRARY TO FCC DECISIONS AND EXCEEDS USAC’S AUTHORITY.

USAC’s decision should be reversed because it runs directly contrary to FCC precedents and exceeds USAC’s authority. The FCC has considered and rejected requirements like the one imposed by USAC here—that all CPE and internal connections must be in place in order to receive support—and has likewise recognized that providers like YKHC are entitled to control their equipment and services and should be presumed to act in a commercially reasonable manner. Contrary to 47 C.F.R. 54.702(c)’s express prohibition on USAC making policy decisions, USAC disregarded those Commission decisions and instead has substituted its own judgment and thereby made policy determinations. In addition to being unlawful, this result is unwise, as the uncertainty it engenders will discourage future efforts to deploy large-scale telemedicine projects. The Commission should reject this outcome and restore the denied funding to YKHC.

A. The FCC has expressly declined to adopt USAC’s novel requirement.

USAC’s denial of funding directly conflicts with FCC decisions. In its funding commitment, USAC creates a new requirement out of whole cloth—that providers must “seek and receive the assistance they need [for equipment and internal connections] *before* they order services.”²⁸ According to USAC, “the FCC expects health care providers to obtain the necessary internal connections or equipment before ordering services.”²⁹ This is simply incorrect as a statement of requirement: in fact, the FCC explicitly declined to create such a mandate.

²⁸ *Id.* at 3 (emphasis in Letter).

²⁹ *Id.* at 4.

In both the 1997 *First Universal Service First Report and Order*,³⁰ and again in its 2003 review of rural health care processes,³¹ the Commission emphatically *declined* to impose requirements that rural health care providers have CPE or internal connections in place prior to ordering services. In comments leading to the landmark 1997 order establishing the rural health care program, the United States Telecom Association had expressed concern “that some health care providers may not have the necessary internal connections or customer premises equipment to use the services requested.”³² While the FCC acknowledged these concerns, it found “no additional requirements are necessary.”³³ Instead, the FCC expressed its confidence “that those providers will seek and receive the assistance they need before they order services” because it recognized that health care providers will not want to “waste their own resources by paying even the significant urban rates for such services.”³⁴ The FCC concluded that “those [safeguards] we adopt, coupled with the fact that the health care provider must still pay urban rates for services covered by support mechanisms, should sufficiently deter frivolous and wasteful requests.”³⁵

³⁰ *Id.* at 3, citing 12 FCC Rcd 8776 ¶ 727 (1997).

³¹ *Rural Health Care Support Mechanism*, 18 FCC Rcd 24546, 24575-6 ¶ 58 (2003).

³² Universal Service Order, 12 FCC Rcd at 9151, ¶ 727.

³³ *Id.*

³⁴ *Id.*

³⁵ *Id.* The Universal Service Order establishes the following provider requirements:

1) that the requester is a public or nonprofit entity that falls within one of the seven categories set forth in the definition of health care provider in section 254(h)(5)(B); n1877

2) unless the requested service is supported under section 254(h)(2)(A), that the requester is physically located in a rural area (OMB defined non-metro county or Goldsmith-defined rural section of an OMB metro county); or, if the requested service is supported under section 254(h)(2)(A), that the requester cannot obtain toll-free access to an Internet service provider;

3) that the services requested will be used solely for purposes reasonably related to the provision of health care services or instruction that the

In 2003, the FCC again considered whether it should adopt additional rules to govern the selection of the most cost-effective services. Once again, the Commission concluded, “the current rules are adequate to ensure that health care providers select the most cost-effective services. Our certification requirements, combined with the requirement that health care providers remain responsible for a significant portion of service costs (i.e., the urban rate of telecommunications services and 75% of Internet access) will ensure that rural health care providers make prudent economic decisions.”³⁶ Thus, the FCC again declined to adopt the rule that USAC has now imposed that all CPE and internal connections be in place before support can be rendered for a facility.

USAC is not authorized to overrule these longstanding FCC decisions or to “supplement” the FCC’s carefully chosen and limited safeguards with ones of its own choosing. Part 54.702(c) of the Commission’s rules makes it absolutely clear that “[t]he Administrator may not make policy, interpret unclear provisions of the statute or rules, or interpret the intent of Congress.” Indeed, the rule specifies that “[w]here the Act or the Commission’s rules are unclear, or do not address a particular situation, the Administrator shall seek guidance from the Commission.” Here, this concern is heightened because the FCC has expressly refused to adopt the rule that

health care provider is legally authorized to provide under the law of the state in which they are provided;

4) that the services will not be sold, resold, or transferred in consideration of money or any other thing of value;

5) if the services are being purchased as part of an aggregated purchase with other entities or individuals, the full details of any such arrangement governing the purchase, including the identities of all co-purchasers and the portion of the services being purchased by the health care provider;

6) that it is ordering the most cost-effective method(s) of providing the requested services.

Id., at 9150-51, ¶ 726.

³⁶ *Rural Health Care Support Mechanism*, 18 FCC Rcd 24546, 24575-6 ¶ 58 (2003); *see also* Attachment D (GCI May 5, 2010 Email to USAC).

USAC has improperly applied and could, itself, impose this requirement only after a rulemaking. There has been no such rulemaking, hence the Commission must reverse USAC's funding denial.

Beyond the lack of authority, USAC's purported adoption of this new requirement is simply bad policy. Unannounced changes in RHC rules—particularly under the guise of review procedures—impose new, non-transparent and unavoidable burdens on carriers and rural healthcare providers alike, as they cannot comply with rules about which they do not know. As a major provider of RHC services in Alaska, GCI is in a better position than most to know of any changes in regulation or policy, yet it had no reason to believe that a gap between service initiation and VTC installation would result in a denial of YKHC's funding for the services YKHC actually requested and that GCI actually provided. With any change in policy that might increase liability for telecommunications carriers, the Commission's rulemaking procedure is essential to ensuring that all providers and carriers have notice and the opportunity to comply with the Commission's rules.

B. Providers, not USAC, must determine their telecommunications needs.

Under FCC rules, the rural health care provider, not USAC, is entitled to make decisions about its own telecommunications needs. The rural health care provider is tasked with determining its bandwidth needs and managing the installation of and transition to new services.

USAC wrongfully denied funding for the YKHC circuits for the time prior to the VTC equipment installation dates. As an initial matter, this funding denial should be reversed because the unfunded bandwidth indisputably served YKHC's core mission of providing reliable, affordable, and efficient health care services to the residents of the Y-K Delta beginning on the

dates the circuits were accepted.³⁷ These uses include VoIP telephone service, e-mail, Internet connectivity, and other telemedicine activities. It therefore was—and remains—“reasonably relate[d]” to the healthcare needs of southwest Alaska.³⁸

Furthermore, the management and timing of the installation project is a matter under the purview of YKHC—not USAC. Under FCC rules and orders, YKHC is entitled to manage this process in the manner it finds most effective, without second-guessing by USAC. As the FCC has stated, “rural health care providers are best able to determine what telecommunications services best meet their needs”³⁹ and “[o]ur certification requirements, combined with the requirement that health care providers remain responsible for a significant portion of service costs (*i.e.*, the urban rate of telecommunications services and 75% of Internet access) will ensure that rural health care providers make prudent economic decisions.”⁴⁰ USAC’s denial of funding based on a phantom requirement for prior installation of CPE and internal connections micromanages YKHC’s deployment of its telemedicine services and contravenes the FCC’s sensible rule vesting decisions regarding equipment and services with the health care provider that will use those equipment and services. The decision, therefore, cannot stand.

C. A day-one requirement for eligible use of services is unreasonably inflexible.

USAC’s decision denying funding excluded the *entire* period between when the circuits were accepted and when the VTC equipment was installed—allowing not even a single day of delay. Disallowing even a brief delay in installation imposes unreasonable liability on rural health care providers and their service providers, despite good faith efforts to install equipment

³⁷ Attachment O at 10 (YKHC May 4, 2009 Response to USAC April 14, 2009 Request for Information).

³⁸ *See* 47 C.F.R. § 54.621.

³⁹ 14 FCC Rcd 18756, 18770 ¶ 21 (1999).

⁴⁰ 18 FCC Rcd 24546, 24575-6 ¶ 58 (2003).

in a timely manner. USAC's decision to withhold almost \$1.6 million of RHC funding on this basis threatens the viability of telemedicine programs, which provide reliable, affordable, and efficient health care services to remote rural populations.

USAC's failure to appreciate that even brief periods of delay may be unavoidable in some circumstances threatens the ability of rural health care providers to receive the support necessary for them to provision high-speed bandwidth to rural areas. For the very same reasons that telemedicine is critically needed in rural areas, providers serving these areas will likely face challenges including weather and terrain when deploying equipment and services. As the FCC has recognized,⁴¹ these providers already have incentives to ensure that their deployments are prompt and cost-effective, both to maximize services to their patients and to minimize their own costs. Lost support may be debilitating for a rural health care provider, or may unfairly place the financial risk of providing these services on carriers. Uncertainty about these costs will create significant disincentives for health care providers and telecommunications carriers to devise and install networks essential to the provision of telemedicine services, particularly where providers and service providers develop new, innovative models to deliver rural health care like the Y-K project. USAC's decision therefore threatens not only YKHC and GCI, but also future participation in RHC programs.

Notably, in its denial of funding, USAC claims that weather-related installation delays are foreseeable in remote locations such as the Y-K Delta.⁴² Even if weather-related delays are foreseeable in these types of locations, they are not avoidable. Indeed, common sense would indicate that extreme weather is *more* likely to affect projects in remote and rural locations where

⁴¹ *Rural Health Care Support Mechanism*, 18 FCC Rcd 24546, 24575-6 ¶ 58 (2003).

⁴² Attachment R at 4 (USAC June 24, 2010 Funding Year 2008 Funding Commitment Letter).

urban infrastructure is unavailable to help mitigate its effects. Surely the FCC could not intend carriers or rural health care providers to bear the unavoidable cost of such delays.

Finally, funding was denied even though the circuits were used for supported services other than telepsychiatry (which required functioning VTC equipment) beginning on the circuit start dates, as explained above. These circuits were therefore “reasonably relate[d]” to the healthcare needs of southwest Alaska and entitled to full funding.⁴³ These facts warrant alone warrant reversal.

IV. USAC’S DENIAL CONTRAVENES THE FCC’S STATED GOAL OF PROMOTING AND EXPANDING RURAL HEALTH CARE.

A. FCC policy, as expressed in the National Broadband Plan and ongoing Rural Health Care rulemaking proceeding, supports expanding USF support for telemedicine.

The FCC has worked hard over the past year and beyond to advance a comprehensive policy promoting and expanding the use of telemedicine and rural health care connectivity. The FCC has found, even “today, too many clinics and hospitals lack affordable access to broadband connectivity adequate to handle basic telehealth tasks, like transmitting an x-ray, MRI, or other electronic medical records, or consulting remotely with a doctor.”⁴⁴ The RHC program should be used to its fullest extent to increase connectivity and promote new and complex network solutions. YKHC’s own network solution is a prime example of how rural healthcare providers can harness technology to provide advanced medical services where they would otherwise not be available.

Removing unnecessary barriers to funding—and avoiding new ones—is essential to this goal. Telemedicine and other health care technologies, “usually grouped under the name health

⁴³ See 47 C.F.R. § 54.621.

⁴⁴ Statement of Chairman Julius Genachowski Re: *Rural Health Care Support Mechanism*, Notice of Proposed Rule Making, WC Docket No. 02-60 at 105 (2010) (“Rural Health Care Support”).

information technology (IT), offer the potential to improve health care outcomes while simultaneously controlling costs and extending the reach of the limited pool of health care professionals.”⁴⁵ As the National Broadband Plan (“NBP”) found, broadband “enables efficient exchange of patient and treatment information by allowing providers to access patients’ electronic health records (EHRs) from on-site or hosted locations;” “removes geography and time as barriers to care by enabling video consultation and remote patient monitoring;” and “provides the foundation for the next generation of health innovation and connected-care solutions.”⁴⁶

On July 15, 2010, the FCC published the *Rural Health Care Universal Service Support Mechanism Notice of Proposed Rulemaking* (“RHC NPRM”), intended to implement the recommendations of the National Broadband Plan and introduce “a new and transformed rural health care connectivity program that would expand investment in broadband for medically underserved communities across the country.”⁴⁷ In the RHC NPRM, the FCC proposes a “package of reforms that would expand the use of broadband to improve the quality and delivery of health care.”⁴⁸ Pursuant to the NBP, the FCC’s stated “aim [is] to encourage maximum utilization of these solutions.”⁴⁹ As holder of the purse strings, USAC is essential to achieving the FCC’s goals. By making on-the-ground decisions about funding, USAC is in a unique position to facilitate the FCC’s goals—or, as here, to frustrate them.

⁴⁵ Federal Communications Commission, *Connecting America: The National Broadband Plan* at 199, Section 10 (2010), *avail. at* <http://download.broadband.gov/plan/national-broadband-plan.pdf> (“NBP”).

⁴⁶ *Id.* at 201.

⁴⁷ Statement of Chairman Julius Genachowski Re: *Rural Health Care Support Mechanism*, Notice of Proposed Rule Making, WC Docket No. 02-60 at 105 (2010) (“Rural Health Care Support”).

⁴⁸ *Id.*

⁴⁹ NBP at 199.

B. New and unexpected barriers to funding are in clear conflict with the FCC's goals.

USAC's role in evaluating and approving RHC funding puts it in a unique position to facilitate the FCC's goals. When USAC improperly impedes the funding process, however, it is at cross-purposes with the FCC's stated goals of promoting and expanding rural health care connectivity. As the FCC has found, many health care providers fail to take advantage of RHC support because the application process is too complex to justify participation for subsidies that are often seen as too low.⁵⁰ As USAC's conduct in this situation has demonstrated, this fear may indeed be well founded. Here, USAC manufactured a new requirement, relied on that new requirement to deny funding, and took nearly a year and half to reach its novel (and impermissible) decision. Other providers considering participating in the RHC program will hardly be encouraged by YKHC's experience.

New and unexpected barriers to funding create uncertainties and disincentives for both rural health care providers and telecommunications carriers seeking to create broadband network solutions for those providers. Unexpected denial of support—especially in such extraordinary amounts—could be ruinous for a rural health care provider. Or, depending on the contractual agreement between the rural health care provider and the carrier, a carrier may be unfairly denied reimbursement for services rendered. As in this case, the reasons for denial of funding may be problems that the carrier did not—and could not—have anticipated or even known about. It would be shockingly unfair if a carrier's payment for services rendered depended on rules about which it did not know and delays that were beyond its control.

⁵⁰ *Id.* at 214 (“Thousands of eligible rural health care providers currently do not take advantage of this program. Some claim that this is because the subsidy is too low and the application process is too complex to justify participation.”).

USAC's evaluation process also creates disincentives for rural health care providers and telecommunications carriers. This situation is an excellent example of the frustration and cost caused by USAC's repeated inquiries into often irrelevant issues and demands for information not typically provided. Drawing out the process in this way increases the costs of RHC support to both rural health care providers and telecommunications carriers, and adds to the uncertainty of the funding process.

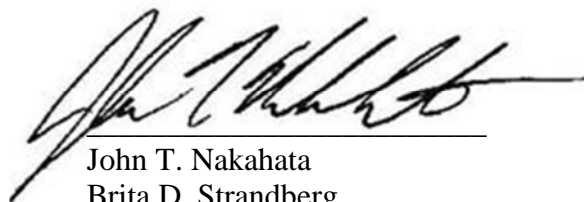
The Commission should reject USAC's attempts to erect barriers to RHC funding for telemedicine. Reducing uncertainty and the potential for such harsh outcomes will facilitate the Commission's goals of promoting telemedicine and encouraging rural health care providers to take advantage of RHC support.

V. CONCLUSION

For these reasons, GCI respectfully requests that the Commission reverse the USAC Decision denying funding to YKHC, and provide the full funding commitment sought by YKHC.

Tina Pidgeon
Vice-President –
Federal Regulatory Affairs
Christopher Nierman
Director – Federal Regulatory Affairs
GENERAL COMMUNICATION, INC.
1350 I Street, N.W., Suite 1260
Washington, D.C. 20005
(202) 457-8812

Respectfully submitted,



John T. Nakahata
Brita D. Strandberg
Rachel Petty
WILTSHIRE & GRANNIS LLP
1200 Eighteenth Street, N.W.
Washington, D.C. 20036
(202) 730-1300

Counsel for General Communication, Inc.

August 23, 2010